Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NOVA HEALTHCARE CENTERS
110 CYPRESS STATION SUITE 280
HOUSTON TX 77090

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

DALLAS NATIONAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 20

MFDR Tracking Number

M4-10-4999-01

MFDR Date Received

AUGUST 3, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "No authorization"

Amount in Dispute: $1,314.42

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor's complaint involves dates of service March 3, 2010, March 5, 2010, March 8, 2010, March 10, 2010 and March 12, 2010. These services provided to the Claimant were physical therapy services. The services were provided without obtaining pre-authorization, thus they were denied."

Response Submitted by: Lewis & Backhaus PC, 14100 Dallas Parkway 400, Dallas, TX 75214

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 3, 2010 through March 12, 2010	Physical Therapy Services	$1,314.42	$1,297.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600 sets out the procedures for obtaining preauthorization.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

- EOBs were not submitted by either party.

Issues

1. Did the services provided by the requestor require preauthorization?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.600(p)(5)(C)(i), non-emergency health care requiring preauthorization includes: (5)physical and occupational therapy services... except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following: the date of injury... The claimant was injured on February 26, 2010; the requestor rendered physical therapy for dates of service March 3, 2010 through March 12, 2010. The treatment/services were rendered within two weeks of the date of injury; therefore, the disputed dates of service will be reviewed in accordance with 28 Texas Administrative Code 134.203(b)(1).

   Per 28 Texas Administrative Code §134.203(b)(1) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.

   - CPT Code 97535 is a component procedure to CPT Code 97530. The use of an appropriate modifier may be allowed; however, review of the medical bill finds that the requestor did not attach a modifier. As a result the amount ordered is $0.00

   28 Texas Administrative Code §134.203(c) states, in pertinent part, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications (1) … For surgery when performed in a facility setting, the established conversion factor to be applied is $66.32… (2) Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year." The MAR for the payable services may be calculated by (2011 TDI-DWC Surgery Conversion Factor / MEDICARE CONVERSION FACTOR) x Facility Price = MAR.

   - CPT Code 97110 - (54.32÷36.0791) x $43.39 x 12 units = $520.69
   - CPT Code 97112 - (54.32÷36.0791) x $45.00 x 10 units = $450.02
   - CPT Code 97530 - (54.32÷36.0791) x $46.61 x 7 units = $326.29
2. Review of the submitted documentation finds that the requestor has sufficiently supported the treatment was rendered as billed. As a result, the amount ordered is $1,297.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,297.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,297.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 19, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.